

Event Number:

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Social Security Number:

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Social Security Number:

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6) Damages - Total Reimbursement Request Cannot Exceed \$5,000**6a) - Kitchen -- Category Cap \$560**

- ☐ (1) Equipment/Furnishings \$560 maximum
- ☐ (2) Food \$50 For 1 Person
\$25 for each additional person

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6b) - Bathroom -- Category Cap \$150

- ☐ (1) Personal Hygiene Items \$30 per person

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6c) - Bedroom Furnishings -- Category Cap \$875

- ☐ (1) Bedroom Furnishings \$250 max per person
EXAMPLE: mattress, box springs, frame, storage containers
- ☐ (2) Clothing \$145 max per person

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6d) - Other Items

- ☐ (1) HVAC \$2,100 installed
Air Conditioning covered only with proof of medical necessity
- ☐ (2) Water Heater \$425 installed
- ☐ (3) Dehumidifier \$150 maximum
- ☐ (4) Sump Pump (flood event only) \$200 installed
- ☐ (5) Electrical/Mechanical \$300 maximum
- ☐ (6) Vehicle Repair \$500 maximum
Does not cover recreation-use vehicles, such as boat, RV, ATV, etc.
- ☐ (7) Infant Car Seat \$40 maximum

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6e) - Minor Home Repair / Materials -- Category Cap \$1,000

- ☐ (1) Structural Components EXAMPLE: foundation, roof
- ☐ (2) Interior EXAMPLE: floors, walls, ceilings, doors, windows, carpet

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6f) - Temporary Housing -- Daily Cap \$50.00

- ☐ (1) Temporary Housing

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 days max \$50 per day

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6g) - Total Requested Reimbursement -- Maximum \$5,000

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7) Signatures

I attest that the information provided on this form is true and accurate. I am providing this information to the Iowa Department of Human Services, Homeland Security and Emergency Management, and County Emergency Management to request reimbursement for expenses under the Iowa Individual Disaster Grant Program. I authorize the re-release of this information to other aid organizations and persons to administer this program as determined necessary by the Iowa Department of Human Services. I attest that persons receiving assistance in this household are legal residents of the United States. I understand that I am not eligible for benefits under this program if I have insurance that covers losses claimed or if I have received assistance from other programs and that this program does not provide payment for insurance deductibles. I understand and agree that if expenses claimed on this form are paid for by another entity or program, including a charity, Federal Emergency Management, Small Business Administration, I will repay the funds received to the State of Iowa. I understand I have a right to withdraw this claim. I understand I have a right to appeal eligibility and damage award decisions within 15 days of a decision.

Applicant:

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Date:

Month	Day	Year

I confirm that (1) The address provided on the application is a valid address and is reasonably believed to be in the disaster-affected area, and (2) Disaster-related expenses were possible as a result of the current disaster. The office of Iowa Homeland Security Emergency Management will maintain copies of this application and receipts for a period of five years.

County Emergency Management Coordinator or Designee:

Date (MM/DD/YYYY)

County Number:

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Iowa Department of Human Services Designated Official:

Date (MM/DD/YYYY)

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Original receipts for all replacement items must be submitted with the application. Purchase dates on each receipt must be no earlier than the first date of the disaster event and within 45 days of the Governor's declaration of a qualifying disaster event.